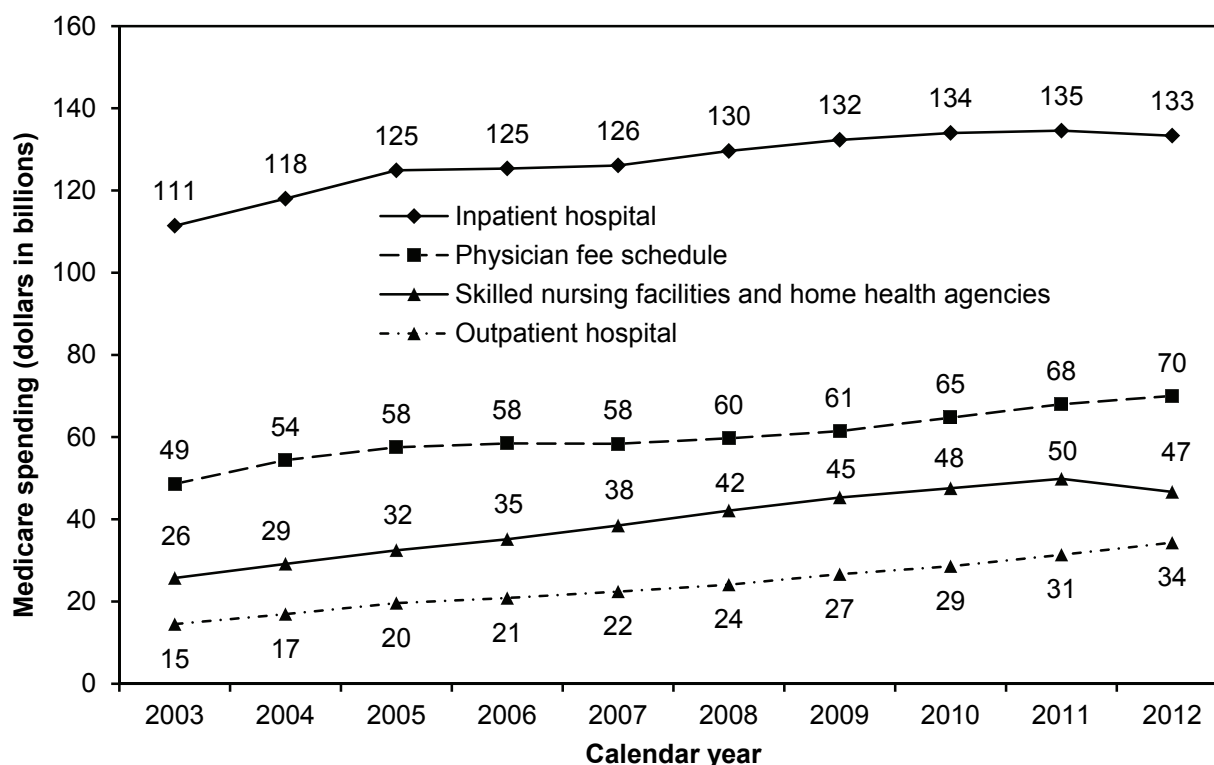


SECTION

1

**National health care and
Medicare spending**

Chart 1-1. Aggregate Medicare spending among FFS beneficiaries, by sector, 2003–2012

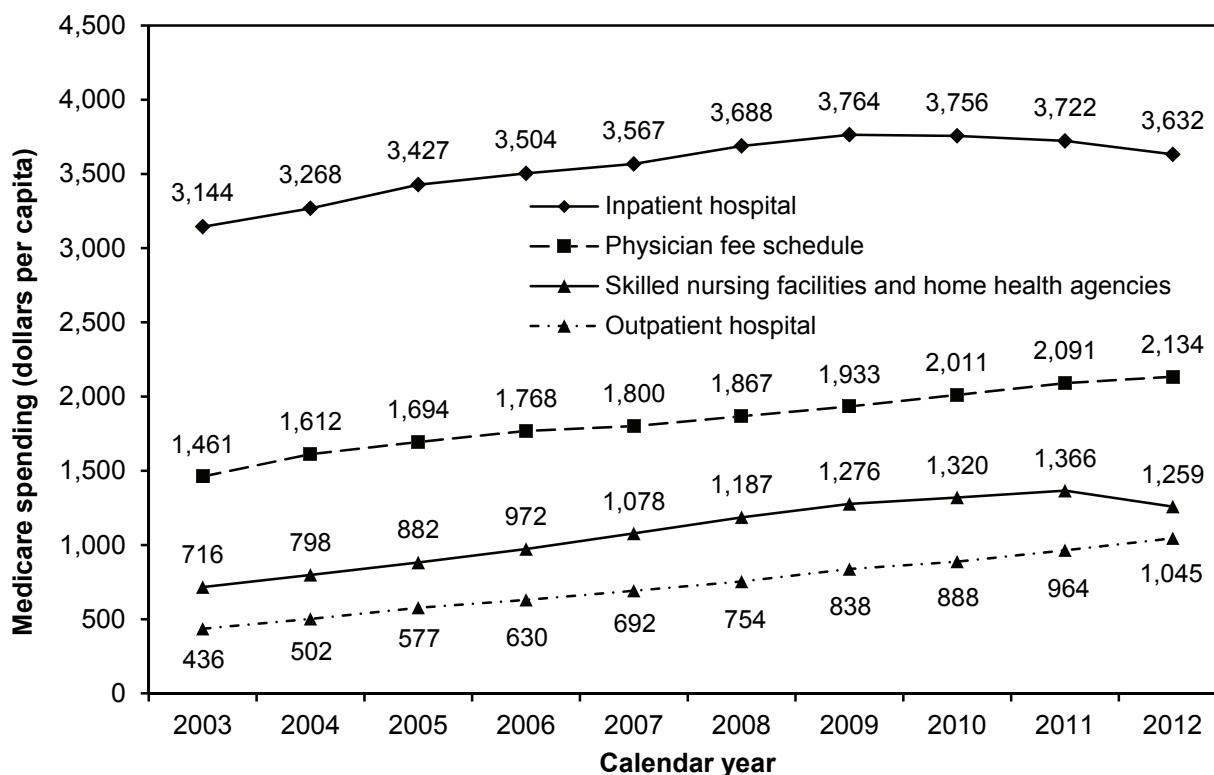


Note: FFS (fee-for-service). "Physician fee schedule" includes spending on services provided by physicians and other health professionals such as nurse practitioners, physician assistants, and physical therapists. Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. Spending for Medicare Advantage enrollees is also not included.

Source: **AT THE TIME THIS DATA BOOK WAS PREPARED, THE MEDICARE TRUSTEES' REPORT (WHICH IS THE CUSTOMARY SOURCE OF DATA FOR THIS CHART) HAD NOT YET BEEN RELEASED FOR 2014. THIS CHART REFLECTS DATA FROM THE 2013 MEDICARE TRUSTEES' REPORT. THE READER IS ADVISED TO CONSULT THE 2014 TRUSTEES' REPORT DIRECTLY, WHEN AVAILABLE, FOR THE MOST CURRENT VERSION OF THESE DATA.**

- Medicare spending among FFS beneficiaries has increased significantly since 2003 across all sectors, even though recently spending growth has slowed. The slowdown in spending growth is partly attributable to a decline in the growth of FFS enrollment since the number of Medicare Advantage enrollees has increased.
- Spending growth for inpatient hospital services, the sector with the highest level of spending, declined from an average annual 4.0 percent from 2003 to 2006 to 1.8 percent from 2006 to 2009 to 0.3 percent from 2009 to 2012. That slowdown is partly attributable to a shift in service volume from the inpatient setting to the outpatient setting, as well as the decline in the growth of FFS enrollment, but it may also reflect broader economic conditions. Despite the slowdown, spending on inpatient hospital services increased, on aggregate, 19.7 percent from 2003 to 2012.
- Spending growth for outpatient hospital services remained strong throughout the period, averaging 12.8 percent per year from 2003 to 2006, 8.5 percent per year from 2006 to 2009, and 8.8 percent per year from 2009 to 2012. Spending on outpatient hospital services increased, on aggregate, 136.5 percent from 2003 to 2012.

Chart 1-2. Per capita Medicare spending among FFS beneficiaries, by sector, 2003–2012



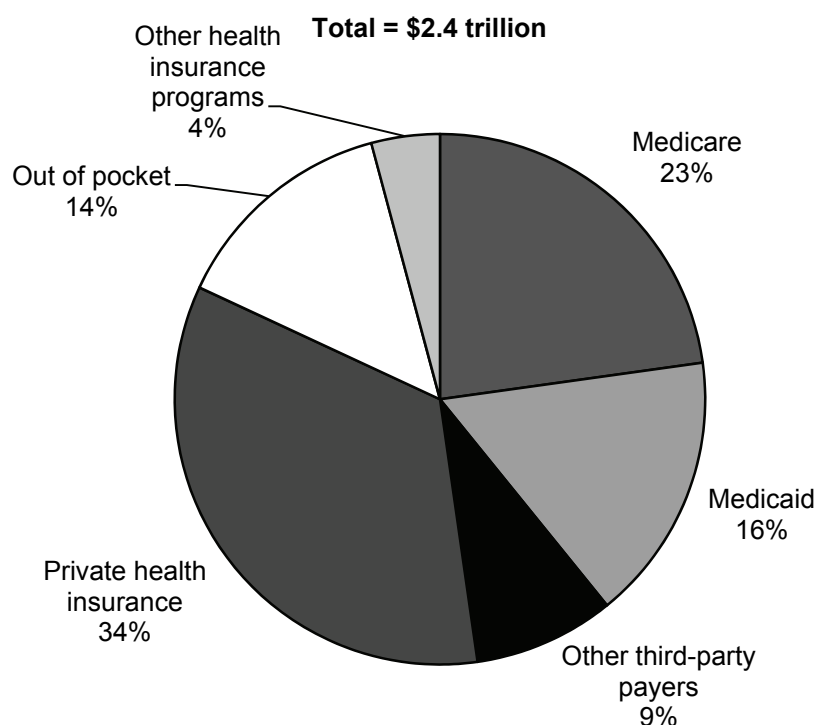
Note: FFS (fee-for-service). "Physician fee schedule" includes spending on services provided by physicians and other health professionals such as nurse practitioners, physician assistants, and physical therapists. Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. Spending for Medicare Advantage enrollees is also not included. Spending per beneficiary for inpatient hospital services equals spending for the sector (Chart 1-1) divided by FFS enrollment in Part A. Spending per beneficiary for physician fee schedule services and outpatient hospital services equals spending for the sector (Chart 1-1) divided by FFS enrollment in Part B. Spending per beneficiary for skilled nursing facilities and home health agencies equals spending for those sectors (Chart 1-1) divided by total FFS enrollment.

Source: **AT THE TIME THIS DATA BOOK WAS PREPARED, THE MEDICARE TRUSTEES' REPORT (WHICH IS THE CUSTOMARY SOURCE OF DATA FOR THIS CHART) HAD NOT YET BEEN RELEASED FOR 2014. THIS CHART REFLECTS DATA FROM THE 2013 MEDICARE TRUSTEES' REPORT. THE READER IS ADVISED TO CONSULT THE 2014 TRUSTEES' REPORT DIRECTLY, WHEN AVAILABLE, FOR THE MOST CURRENT VERSION OF THESE DATA.**

- Medicare spending per beneficiary in FFS Medicare has increased substantially since 2003 across all sectors, despite slowing down recently.
- Growth in spending per beneficiary for inpatient hospital services, the sector with the highest level of spending, declined from an average annual 3.7 percent from 2003 to 2006 to 2.4 percent from 2006 to 2009 to –1.2 percent from 2009 to 2012. Despite the slowdown, spending per beneficiary for inpatient hospital services increased, on aggregate, 15.5 percent from 2003 to 2012.

Spending per beneficiary for outpatient hospital services remained strong throughout the period, averaging 13.1 percent per year from 2003 to 2006, 10 percent per year from 2006 to 2009, and 7.7 percent per year from 2009 to 2012. Spending per beneficiary for outpatient hospital services increased, on aggregate, 139.8 percent from 2003 to 2012.

Chart 1-3. Medicare is the largest single purchaser of personal health care, 2012

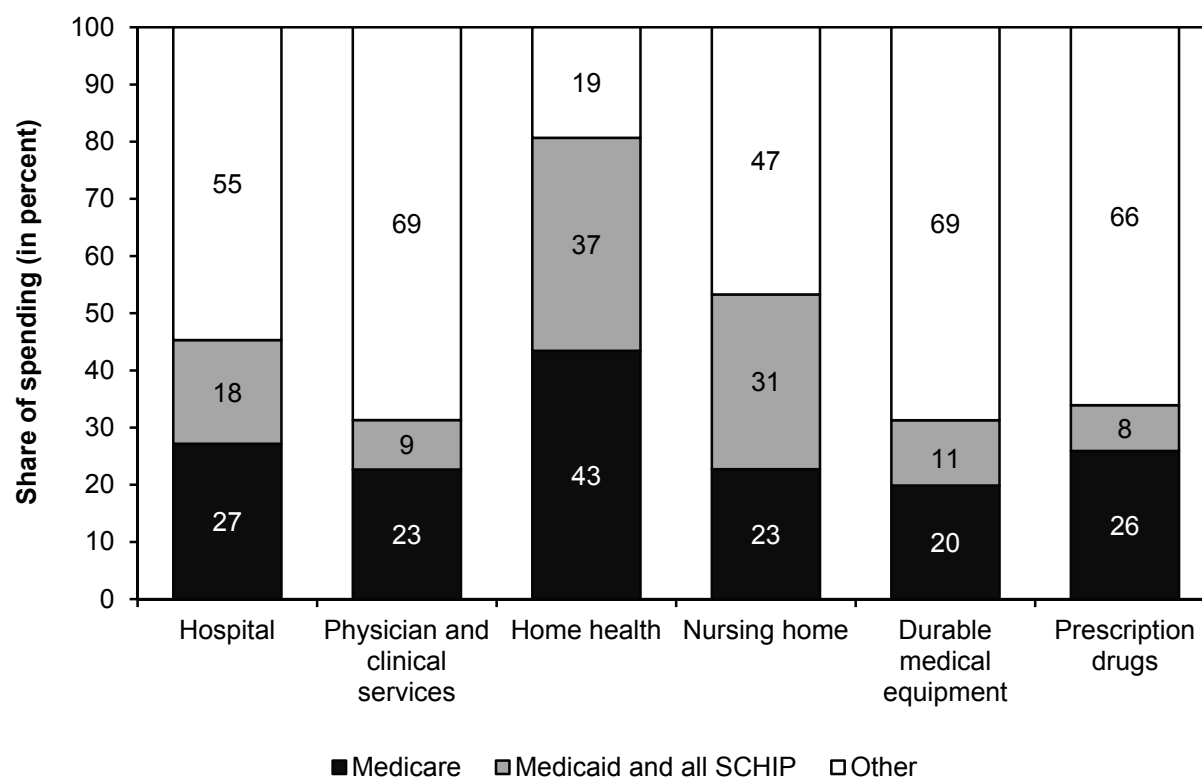


Note: "Personal health care" is a subset of national health expenditures. It includes spending for all medical goods and services that are provided for the treatment of an individual and excludes other spending, such as government administration, the net cost of health insurance, public health, and investment. "Out-of-pocket spending" includes cost sharing for both privately and publicly insured individuals. Premiums are included in the shares of each program (e.g., Medicare, private insurance) rather than in the share of out-of-pocket category. "Other health insurance programs" includes the Children's Health Insurance Program, Department of Defense, and Department of Veterans' Affairs. "Other third-party payers" includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

Source: CMS Office of the Actuary, National Health Expenditure Accounts, "Table 6 Personal Health Care Expenditures; Levels, Percent Change and Percent Distribution, by Source of Funds: Selected Calendar Years 1970–2012," released January 2014.

- Medicare is the largest single purchaser of health care in the United States. Of the \$2.4 trillion spent on personal health care in 2012, Medicare accounted for 23 percent, or \$538 billion (as noted above, this amount includes spending on direct patient care and excludes certain administrative and business costs).
- Thirty-four percent of spending was financed through private health insurance payers, and 14 percent was from consumer out-of-pocket spending.
- Medicare and private health insurance spending include premium contributions from enrollees.

Chart 1-4. Medicare's share of spending on personal health care varies by type of service, 2012

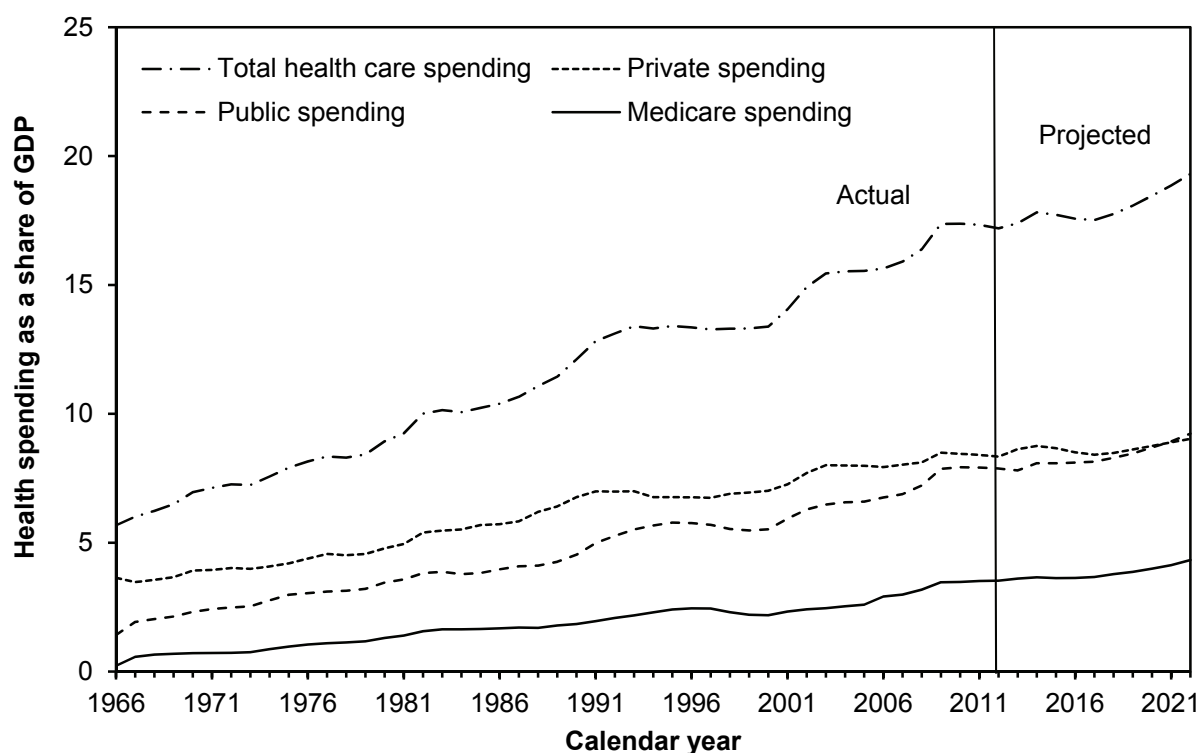


Note: SCHIP (State Children's Health Insurance Program). "Personal health care" is a subset of national health expenditures. It includes spending for all medical goods and services that are provided for the treatment of an individual and excludes other spending, such as government administration, the net cost of health insurance, public health, and investment. "Other" includes private health insurance, out-of-pocket spending, and other private and public spending. Totals may not sum to 100 percent due to rounding.

Source: CMS Office of the Actuary, National Health Expenditure Accounts, "Table 19 National Health Expenditures by Type of Expenditure and Program: Calendar Year 2012," released January 2014.

- While Medicare's share of total personal health care spending was 23 percent in 2012, its share of spending by type of service varied, with a slightly higher share of spending on hospital care (27 percent) and a much higher share of spending on home health services (43 percent), partly because that category, in the chart above, includes hospice services.
- Medicare's share of spending on nursing homes was smaller than Medicaid's share because Medicare pays for nursing home services only for Medicare beneficiaries who require skilled nursing or rehabilitation services, whereas Medicaid pays for custodial care (assistance with activities of daily living) provided in nursing homes for people with limited income and assets.
- In 2012, Medicare accounted for 27 percent of spending on hospital care, 23 percent of physician and clinical services, 43 percent of home health services, 23 percent of nursing home care, 20 percent of durable medical equipment, and 26 percent of prescription drugs.

Chart 1-5. Health care spending has risen as a share of GDP

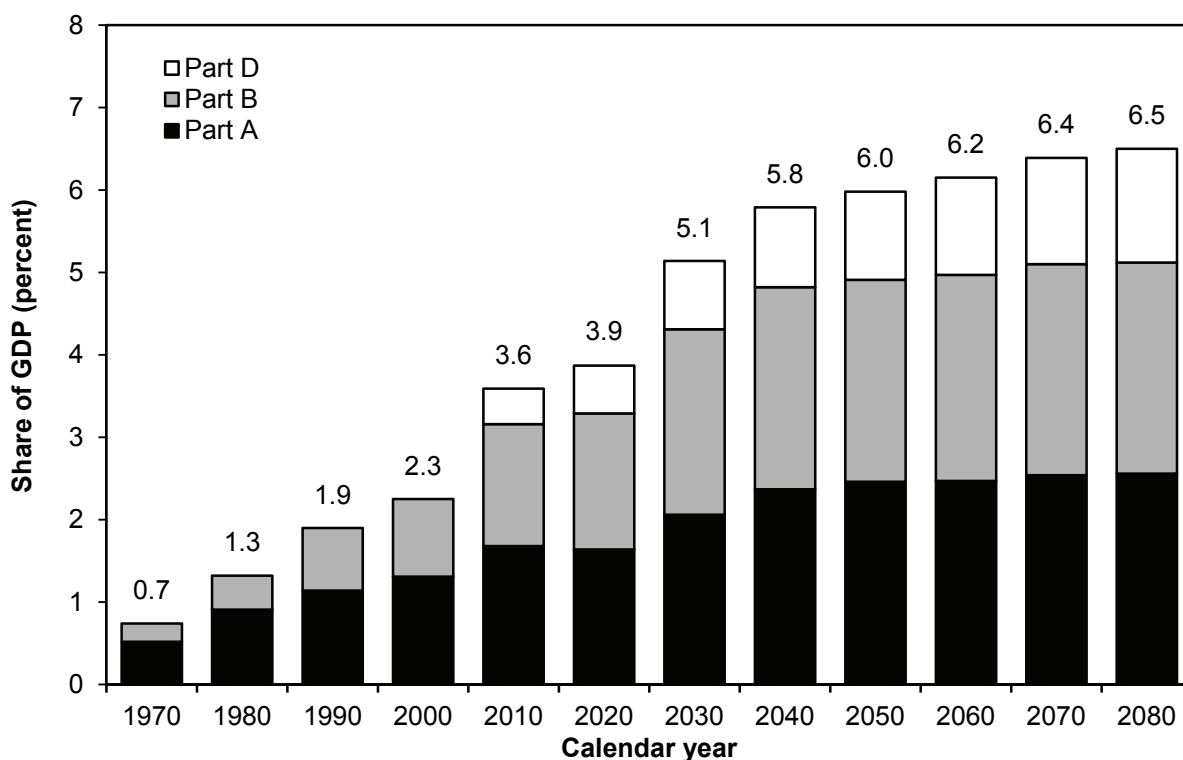


Note: GDP (gross domestic product). "Total health care spending" is the sum of all private and public spending. Medicare spending is one component of all public spending.

Source: CMS Office of the Actuary, National Health Expenditure Accounts 2014.

- Total health care spending consumes an increasing proportion of national resources, accounting for a double-digit share of GDP annually since 1982.
- As a share of GDP, total health care spending increased from about 6 percent in 1966 to about 17 percent in 2009 and has remained around this level through 2012. Projections suggest that total health care spending will make up about 19 percent of GDP by 2022.
- Medicare spending has also grown as a share of the economy, from less than 1 percent at the introduction of the program in 1966 to 3.5 percent in 2012. Projections suggest that Medicare spending will make up 4.3 percent of GDP by 2022.
- In 2012, public spending made up 49 percent of total health care spending, and private spending made up 51 percent. In 2021, public spending is projected to begin to exceed private spending as Medicare enrollment accelerates with the aging of the baby-boom population (individuals born between 1946 and 1964), enrollment in Medicaid expands, and subsidies for coverage purchased in the new health insurance exchanges are provided under provisions of the Patient Protection and Affordable Care Act of 2010.

Chart 1-6. Trustees project Medicare spending to continue to increase as a share of GDP

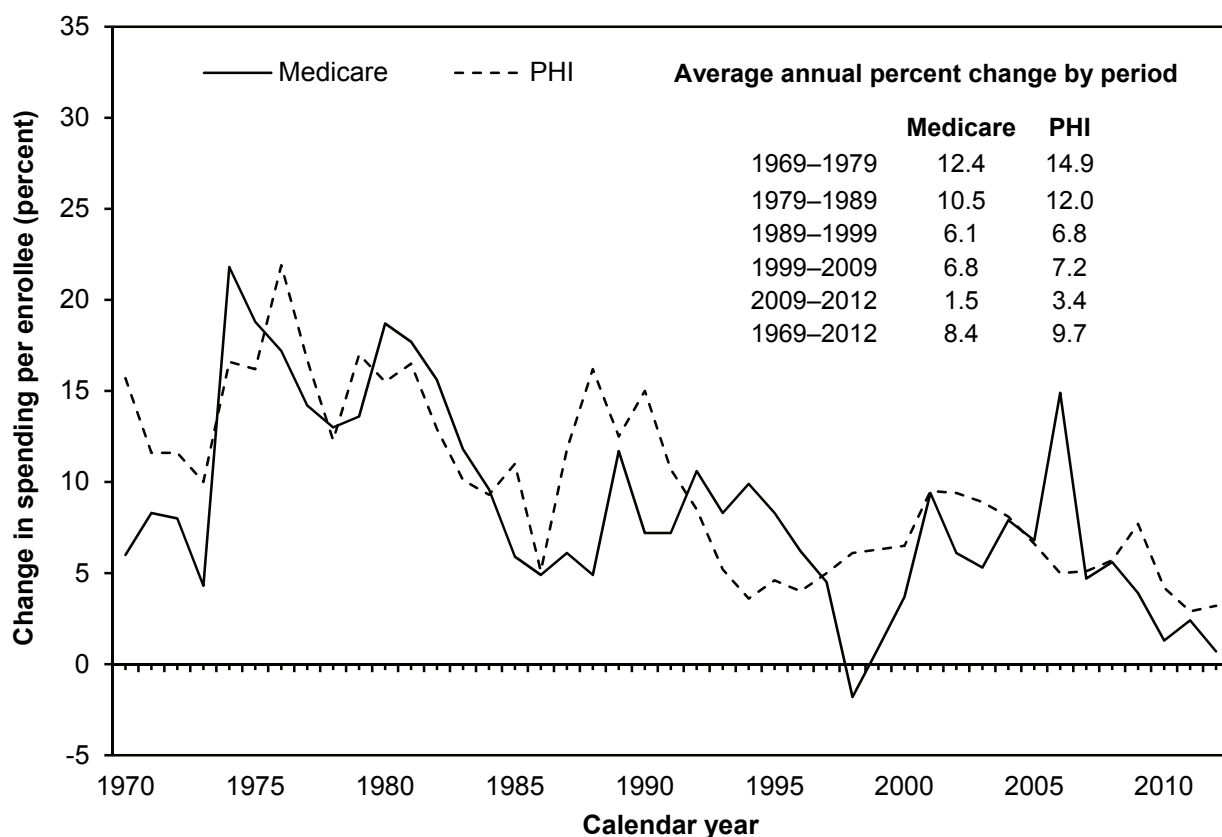


Note: GDP (gross domestic product). These projections are based on the trustees' intermediate set of assumptions.

Source: **AT THE TIME THIS DATA BOOK WAS PREPARED, THE MEDICARE TRUSTEES' REPORT (WHICH IS THE CUSTOMARY SOURCE OF DATA FOR THIS CHART) HAD NOT YET BEEN RELEASED FOR 2014. THIS CHART REFLECTS DATA FROM THE 2013 MEDICARE TRUSTEES' REPORT. THE READER IS ADVISED TO CONSULT THE 2014 TRUSTEES' REPORT DIRECTLY, WHEN AVAILABLE, FOR THE MOST CURRENT VERSION OF THESE DATA.**

- Over time, Medicare spending has accounted for an increasing share of GDP. From less than 1 percent in 1970, it is projected to reach 6.5 percent of GDP in 2080.
- The Medicare trustees project that spending will rise from 3.5 percent of GDP in 2012 to 5.1 percent of GDP by 2030, largely because of the rapid growth in the number of beneficiaries, and then to 6.5 percent of GDP in 2080, with growth in spending per beneficiary becoming the larger factor in later years of the forecast. The rapid growth in the number of beneficiaries began in 2011 and will continue through 2030 as members of the baby-boom generation reach age 65 and become eligible to receive benefits.
- Nominal Medicare spending grew on average 9.1 percent per year over the period from 1980 to 2010, considerably faster than nominal growth in the economy, which averaged 5.7 percent per year over the same time frame. Future Medicare spending is projected to continue growing faster than GDP, averaging 5.5 percent per year between 2010 and 2080, compared with an annual average growth rate of 4.6 percent for the economy as a whole. In other words, Medicare spending is projected to continue rising as a share of GDP, but at a slower pace.

Chart 1-7. Changes in spending per enrollee, Medicare and private health insurance



Note: PHI (private health insurance). Medicare expenditures include both fee-for-service and private plans.

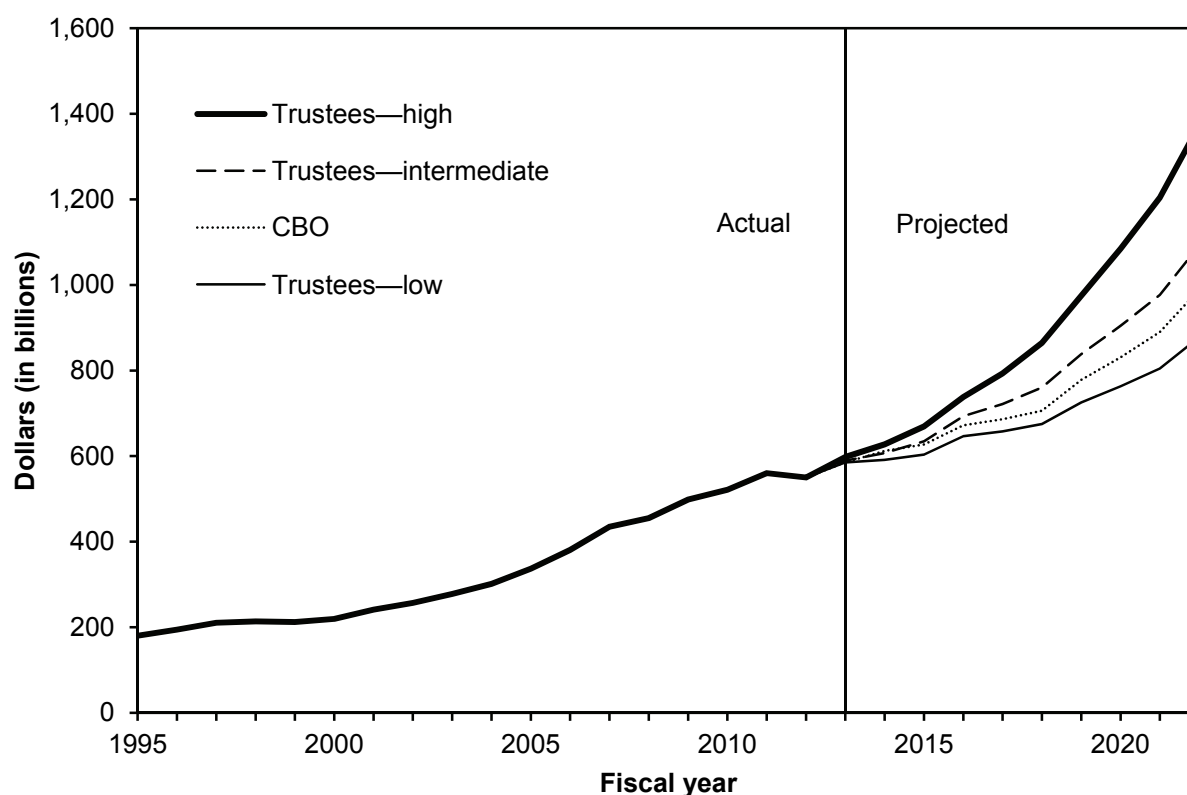
Source: CMS Office of the Actuary, National Health Expenditure Accounts 2014.

- Rates of growth in per capita spending for Medicare and private health insurance have followed a similar pattern over the last four decades. Recently, rates of growth in per capita spending have slowed for both Medicare and private health insurance.

However, differences between the rates of growth appear to be more pronounced since the mid-1980s. Some analysts believe that those differences are attributable to the introduction of the prospective payment system for hospital inpatient services that began in 1985. In their view, that payment system has allowed Medicare greater success than private payers in containing spending growth. Others maintain that the differences are due to the expansion of benefits offered by private insurers and a decline in cost-sharing requirements. More recently, cost-sharing requirements have increased, coinciding with a decline in the growth of per capita spending for private payers.

- Comparisons are problematic since private insurers and Medicare do not buy the same mix of services, and Medicare covers an older population, which tends to be more costly. In addition, spending trends are also affected by changes in the generosity of covered benefits and changes in enrollees' out-of-pocket spending.

Chart 1-8. Trustees and CBO project Medicare spending to exceed \$1 trillion by the early part of the next decade, 1995–2022

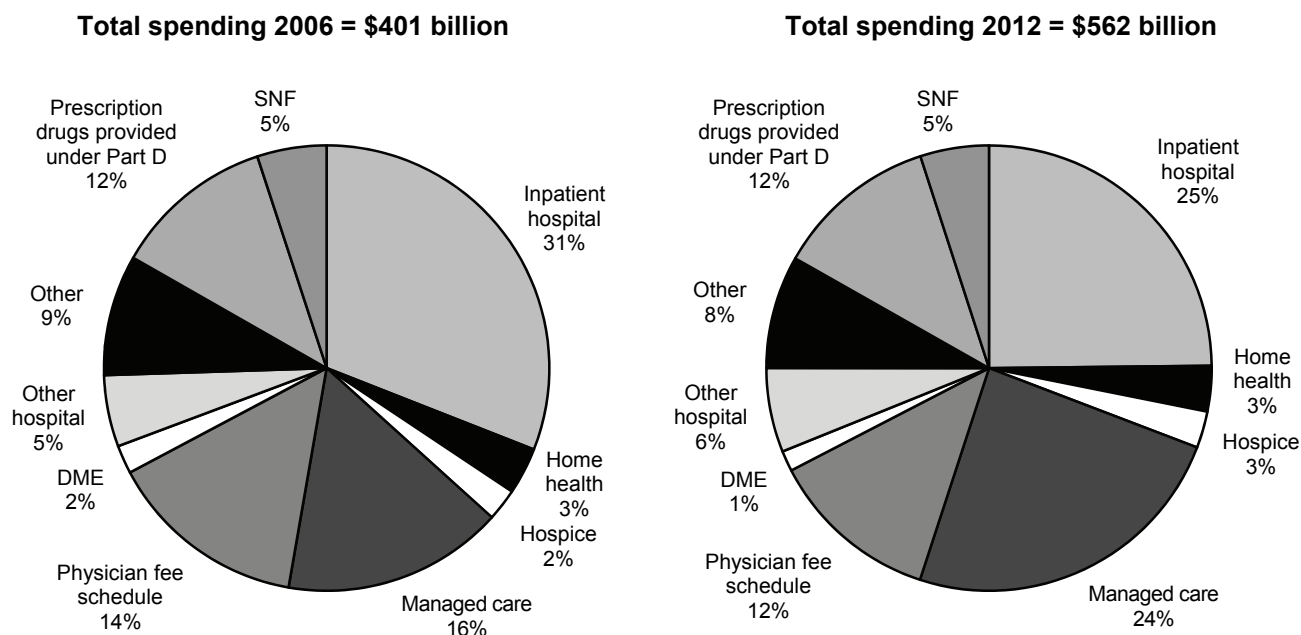


Note: CBO (Congressional Budget Office). All data are nominal, mandatory outlays (benefit payments plus mandatory administrative expenses) by fiscal year.

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- Medicare spending has tripled since 1995, increasing from \$180 billion to \$550 billion by 2012 (these data are by fiscal year and include benefit payments and mandatory administrative expenses).
- CBO projects that spending for Medicare will grow at an average annual rate of 6.0 percent between 2013 and 2022. The Medicare trustees' intermediate projections for 2013 to 2022 assume 7.1 percent average annual growth. Forecasts of future Medicare spending are inherently uncertain, and differences can stem from different assumptions about the economy (which affect annual updates to provider payments) and about growth in the volume and intensity of services delivered to Medicare beneficiaries, among other factors.

Chart 1-9. Medicare spending is concentrated in certain services and has shifted over time

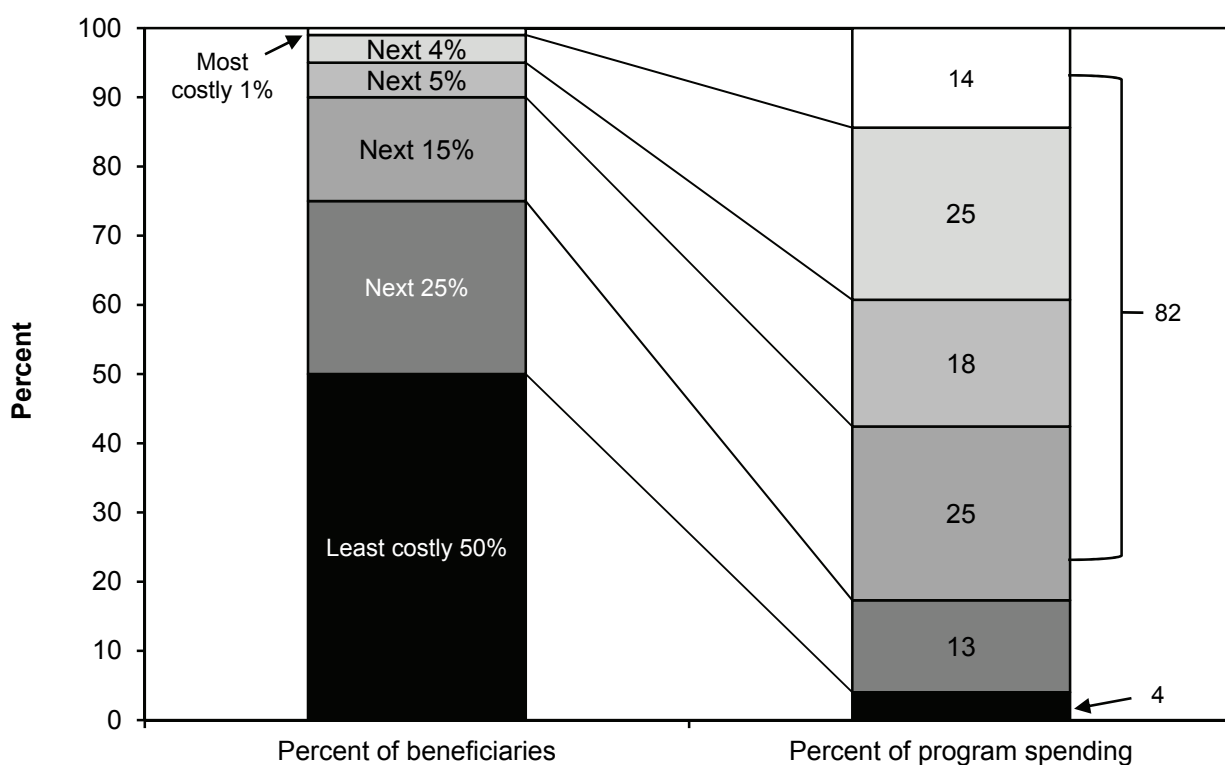


Note: SNF (skilled nursing facility), DME (durable medical equipment). All data are by calendar year. Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. "Other" includes items such as laboratory services, physician-administered drugs, renal dialysis performed in freestanding dialysis facilities, services provided in freestanding ambulatory surgical center facilities, and ambulance. Totals may not sum to 100 percent due to rounding.

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- The distribution of Medicare spending among services has changed over time.
- In 2012, Medicare spending totaled about \$560 billion for benefit expenses. Inpatient hospital services were the largest spending category (25 percent), followed by managed care (24 percent), services reimbursed under the physician fee schedule (12 percent), outpatient prescription drugs provided under Part D (12 percent), and services provided in other settings (8 percent).
- Although inpatient hospital services still made up the largest spending category, spending for those services was a smaller share of total Medicare spending in 2012 than it was in 2006, falling from 31 percent to 25 percent. Spending on beneficiaries enrolled in managed care plans grew from 16 percent to 24 percent over the same period. Medicare managed care enrollment increased 86 percent over the same period.

Chart 1-10. FFS program spending is highly concentrated in a small group of beneficiaries, 2010



Note: FFS (fee-for-service). All data are for calendar year 2010. Analysis excludes beneficiaries with any group health enrollment during the year. "Percent of program spending" total may not sum to 100 percent due to rounding.

Source: MedPAC analysis of 2010 Medicare Current Beneficiary Survey, Cost and Use files.

- Medicare FFS spending is concentrated among a small number of beneficiaries. In 2010, the costliest 5 percent of beneficiaries accounted for 39 percent of annual Medicare FFS spending, and the costliest 25 percent accounted for 82 percent. By contrast, the least costly 50 percent of beneficiaries accounted for only 4 percent of FFS spending.
- Costly beneficiaries tend to include those who have multiple chronic conditions, are using inpatient hospital services, are dually eligible for Medicare and Medicaid, and are in the last year of life.

Chart 1-11. Medicare HI trust fund is projected to be insolvent in 2026 under trustees' intermediate assumptions

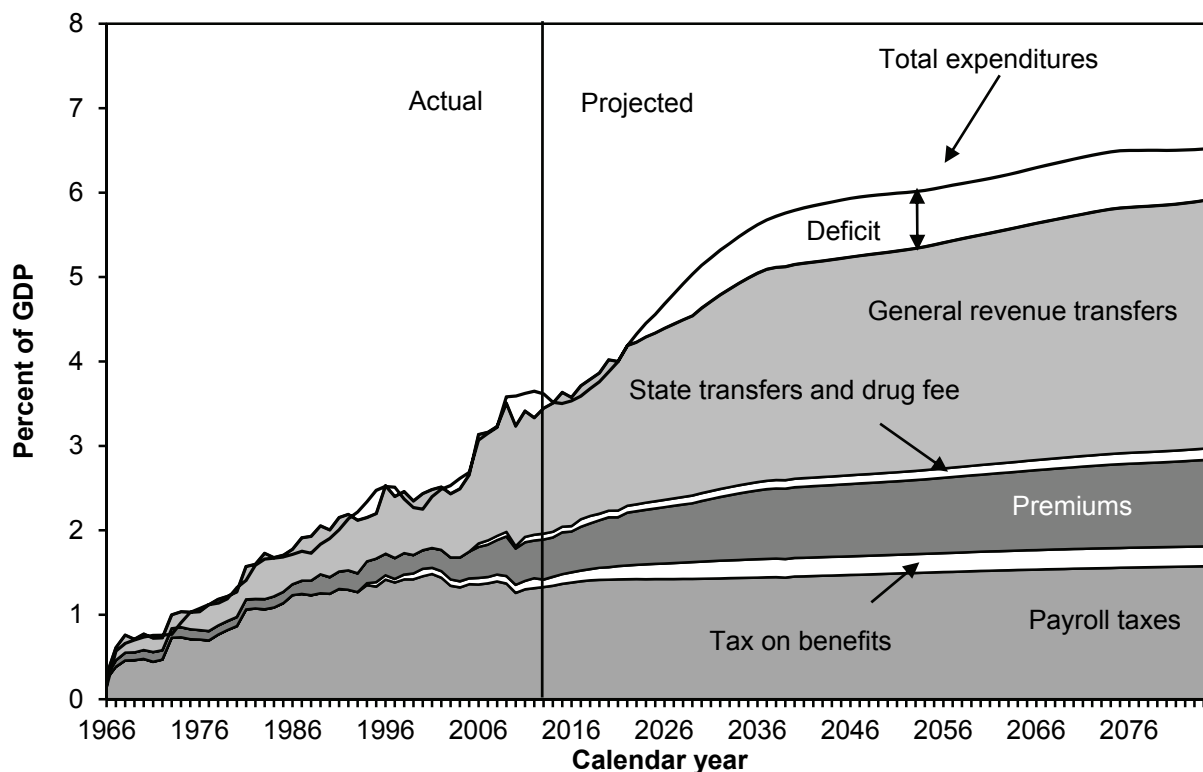
Estimate	Year costs exceed income	Year HI trust fund assets exhausted
High	2008	2019
Intermediate	2008	2026
Low	2008	Never*

Note: HI (Hospital Insurance). All years represent calendar years. The primary source of income for HI is the payroll tax on covered earnings. Other HI income sources include a portion of the federal income taxes that Social Security recipients with incomes above certain thresholds pay on their benefits as well as interest paid on the U.S. Treasury securities held in the HI trust fund.
*Under the low-cost assumption, trust fund assets would start to increase in 2014 and continue to increase throughout the projection period.

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- The Medicare program is financed through two trust funds: one for HI, which covers services provided by hospitals and other providers such as skilled nursing facilities, and one for Supplementary Medical Insurance (SMI) services, such as physician visits and Medicare's prescription drug benefit. Dedicated payroll taxes on current workers largely finance HI spending and are held in the HI trust fund. The HI trust fund can be exhausted if spending exceeds payroll tax revenues and fund reserves. General revenues finance roughly 75 percent of SMI services, and beneficiary premiums finance about 25 percent. (General revenues are federal tax dollars that are not dedicated to a particular use and are made up of income and other taxes on individuals and corporations.)
- The SMI trust fund is financed with general revenues and beneficiary premiums. Some analysts believe that the levels of premiums and general revenues required to finance projected spending for SMI services would impose a significant burden on Medicare beneficiaries and on growth in the U.S. economy.
- HI's expenses exceeded its income in 2008. In 2013, Medicare trustees report that, under the intermediate assumptions, the HI trust fund will be exhausted in 2026. Under high-cost assumptions, the HI trust fund could be exhausted as early as 2019. Under low-cost assumptions, it would remain able to pay full benefits indefinitely.

Chart 1-12. Medicare faces serious challenges with long-term financing

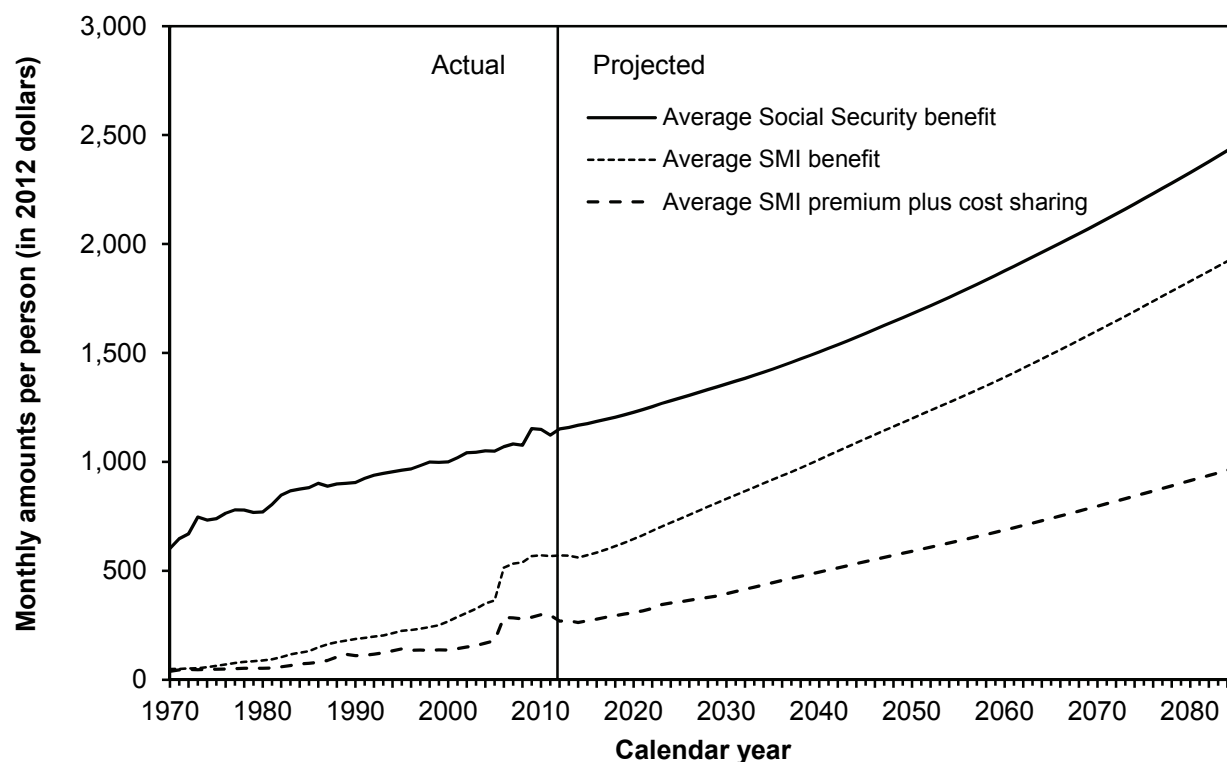


Note: GDP (gross domestic product). These projections are based on the trustees' intermediate set of assumptions. "Tax on benefits" refers to the portion of income taxes that higher income individuals pay on Social Security benefits, which is designated for Medicare. "State transfers" (often called the Part D "clawback") refer to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending. The drug fee is the fee imposed in the Patient Protection and Affordable Care Act of 2010 on manufacturers and importers of brand-name prescription drugs. These fees are deposited in the Part B account of the Supplementary Medical Insurance trust fund.

Source: AT THE TIME THIS DATA BOOK WAS PREPARED, THE MEDICARE TRUSTEES' REPORT (WHICH IS THE CUSTOMARY SOURCE OF DATA FOR THIS CHART) HAD NOT YET BEEN RELEASED FOR 2014. THIS CHART REFLECTS DATA FROM THE 2013 MEDICARE TRUSTEES' REPORT. THE READER IS ADVISED TO CONSULT THE 2014 TRUSTEES' REPORT DIRECTLY, WHEN AVAILABLE, FOR THE MOST CURRENT VERSION OF THESE DATA.

- In 2012, Medicare expenditures exceeded Medicare revenues because of decreased Hospital Insurance payroll tax income caused by the weak economy. The Medicare trustees project that expenditures will continue to exceed revenues in 2013 and 2014.
- From 2015 to 2022, Medicare revenues are expected to exceed Medicare expenditures in part because expenditures are reduced as a result of provisions of the Budget Control Act of 2011 that require a 2 percent sequester of Medicare payments during this period.
- After 2022, the Medicare trustees project that Medicare expenditures will exceed Medicare revenues, and general revenues will grow as a share of total Medicare financing, adding significantly to federal budget pressures.

Chart 1-13. Average monthly SMI premiums and cost sharing are projected to grow faster than the average monthly Social Security benefit



Note: SMI (Supplementary Medical Insurance). "Average SMI benefit" and "average SMI premium plus cost sharing" values are for a beneficiary enrolled in Part B and (after 2006) Part D. Beneficiary spending on outpatient prescription drugs before 2006 is not included.

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- Most Medicare beneficiaries pay their Part B premium by having it withheld from their monthly Social Security benefits. Over time, growth in Medicare premiums and cost sharing has outpaced growth in Social Security benefits.
- Between 1970 and 2010, the average monthly Social Security benefit (adjusted for inflation) increased by an annual average rate of 1.6 percent. Over the same period, average SMI premiums plus cost sharing grew by an annual average of 5.2 percent, and the value of the total SMI benefit grew by an annual average of 6.3 percent.
- The Medicare trustees project that growth in Medicare premiums and cost sharing will continue to outpace growth in Social Security income. Between 2010 and 2040, the average Social Security benefit is projected to grow by 1.0 percent annually (after adjusting for inflation) compared with about 1.7 percent annual growth in average SMI premiums plus cost sharing.

Chart 1-14. Medicare HI and SMI benefits and cost sharing per FFS beneficiary in 2012

	Average benefit (in dollars)	Average cost sharing (in dollars)
HI	\$5,162	\$422
SMI	5,188	1,278

Note: HI (Hospital Insurance), SMI (Supplementary Medical Insurance), FFS (fee-for-service). Dollar amounts are for calendar year 2012 for FFS Medicare only and do not include Part D. "Average benefit" represents amounts paid for covered services per FFS beneficiary and excludes administrative expenses. "Average cost sharing" represents the sum of deductibles, coinsurance, and balance billing paid for covered services per FFS beneficiary.

Source: CMS Office of the Actuary, the 2013 annual report of the Boards of Trustees of the Medicare Trust Funds, and the Medicare and Medicaid Statistical Supplement 2013, CMS Office of Information Services.

- In calendar year 2012, the Medicare program made \$5,162 in HI benefit payments and \$5,188 in SMI benefit payments on average per beneficiary.
- In the same year, beneficiaries owed an average of \$422 in cost sharing for HI, \$1,278 in cost sharing for SMI, and a total of \$1,550 in cost sharing for both.
- Most Medicare beneficiaries have supplemental coverage through former employers, medigap policies, Medicaid, or other sources that fill in much of Medicare's cost-sharing requirements.